STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005971	A. BUILDING _____ B. WING _____	C 09/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION HOSPITAL OF INDIANA INC	4141 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State hospital complaint. Complaint: 00093633 Substantiated; no deficiencies cited. Date of Survey: 09-15-2011 Facility Number: 005971 Surveyor: Deborah Franco, RN Public Health Nurse Surveyor Rehabilitation Hospital of Indiana, Inc. is in compliance with 410 IAC 15-.5-6, Nursing service, Hospital Licensure Rules. QA: claughlin 11/04/11	S 000		